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assistants or nurse practitioners. At least one member is not a member of the clinic or center staff.

(3) The policies include:

(i) A description of the services the clinic or center furnishes directly and those furnished through agreement or arrangement.

(ii) Guidelines for the medical management of health problems which include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services furnished by the clinic or center.

(iii) Rules for the storage, handling, and administration of drugs and biologicals.

(4) These policies are reviewed at least biennially by the group of professional personnel required under paragraph (b)(2) of this section and reviewed as necessary by the RHC or FQHC.

(c) *Direct services*—(1) *General*. The clinic or center staff furnishes those diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at the entry point into the health care delivery system. These include medical history, physical examination, assessment of health status, and treatment for a variety of medical conditions.

(2) *Laboratory*. These requirements apply to RHCs but not to FQHCs. The RHC provides laboratory services in accordance with part 493 of this chapter, which implements the provisions of section 353 of the Public Health Service Act. The RHC provides basic laboratory services essential to the immediate diagnosis and treatment of the patient, including:

(i) Chemical examinations of urine by stick or tablet method or both (including urine ketones);

(ii) Hemoglobin or hematocrit;

(iii) Blood glucose;

(iv) Examination of stool specimens for occult blood;

(v) Pregnancy tests; and

(vi) Primary culturing for transmittal to a certified laboratory.

(3) *Emergency*. The clinic or center provides medical emergency procedures as a first response to common life-threatening injuries and acute illness

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and has available the drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids.

(d) *Services provided through agreements or arrangements*. (1) The clinic or center has agreements or arrangements with one or more providers or suppliers participating under Medicare or Medicaid to furnish other services to its patients, including:

(i) Inpatient hospital care;

(ii) Physician(s) services (whether furnished in the hospital, the office, the patient's home, a skilled nursing facility, or elsewhere); and

(iii) Additional and specialized diagnostic and laboratory services that are not available at the clinic or center.

(2) If the agreements are not in writing, there is evidence that patients referred by the clinic or center are being accepted and treated.

[57 FR 24983, June 12, 1992, as amended at 58 FR 63536, Dec. 2, 1993; 84 FR 51832, Sept. 30, 2019]

§ 491.10 Patient health records.

(a) *Records system*. (1) The clinic or center maintains a clinical record system in accordance with written policies and procedures.

(2) A designated member of the professional staff is responsible for maintaining the records and for insuring that they are completely and accurately documented, readily accessible, and systematically organized.

(3) For each patient receiving health care services, the clinic or center maintains a record that includes, as applicable:

(i) Identification and social data, evidence of consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;

(ii) Reports of physical examinations, diagnostic and laboratory test results, and consultative findings;

(iii) All physician's orders, reports of treatments and medications, and other pertinent information necessary to monitor the patient's progress;

(iv) Signatures of the physician or other health care professional.

(b) *Protection of record information.* (1) The clinic or center maintains the confidentiality of record information and provides safeguards against loss, destruction or unauthorized use.

(2) Written policies and procedures govern the use and removal of records from the clinic or center and the conditions for release of information.

(3) The patient's written consent is required for release of information not authorized to be released without such consent.

(c) *Retention of records.* The records are retained for at least 6 years from date of last entry, and longer if required by State statute.

(Secs. 1102, 1833 and 1902(a)(13), Social Security Act; 49 Stat. 647, 91 Stat. 1485 (42 U.S.C. 1302, 13951 and 1396a(a)(13)))

[43 FR 30529, July 14, 1978. Redesignated at 50 FR 33034, Aug. 16, 1985, as amended at 57 FR 24984, June 12, 1992]

§ 491.11 Program evaluation.

(a) The clinic or center carries out, or arranges for, a biennial evaluation of its total program.

(b) The evaluation includes review of:

(1) The utilization of clinic or center services, including at least the number of patients served and the volume of services;

(2) A representative sample of both active and closed clinical records; and

(3) The clinic's or center's health care policies.

(c) The purpose of the evaluation is to determine whether:

(1) The utilization of services was appropriate;

(2) The established policies were followed; and

(3) Any changes are needed.

(d) The clinic or center staff considers the findings of the evaluation and takes corrective action if necessary.

[71 FR 55346, Sept. 22, 2006, as amended at 84 FR 51832, Sept. 30, 2019]

§ 491.12 Emergency preparedness.

The Rural Health Clinic/Federally Qualified Health Center (RHC/FQHC) must comply with all applicable Federal, State, and local emergency pre-

paredness requirements. The RHC/FQHC must establish and maintain an emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:

(a) *Emergency plan.* The RHC or FQHC must develop and maintain an emergency preparedness plan that must be reviewed and updated at least every 2 years. The plan must do all of the following:

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.

(2) Include strategies for addressing emergency events identified by the risk assessment.

(3) Address patient population, including, but not limited to, the type of services the RHC/FQHC has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.

(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation.

(b) *Policies and procedures.* The RHC or FQHC must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:

(1) Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients.

(2) A means to shelter in place for patients, staff, and volunteers who remain in the facility.

(3) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.